Quick Look Procedure Resource for NON-CRITICAL CARE staff

Sedation Assessment and Safety

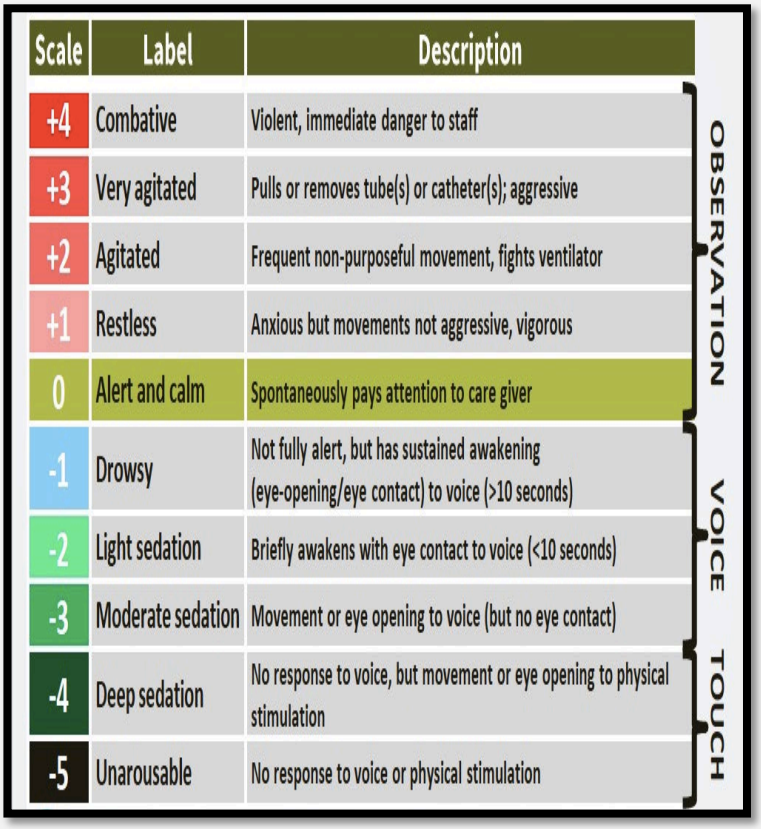
WHEN TO PERFORM

1. All intubated and ventilated patients
2. Every 2-4 hours and as needed
3. Changes in patient ventilation, vital signs
4. When muscle relaxants (paralyzing agents) are used

HOW TO PERFORM

1. Assessing sedation level

- Use Richmond Agitation and Sedation Scale (RASS) (or similar) to assess sedation level
- Lower number = more sedated
- Doctors will tell you what sedation level to aim for – this should NEVER result in an agitated patient



Scale	Label	Description	
+4	Combative	Violent, immediate danger to staff	OBSERVATION
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive	
+2	Agitated	Frequent non-purposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressive, vigorous	
0	Alert and calm	Spontaneously pays attention to care giver	
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (>10 seconds)	VOICE
-2	Light sedation	Briefly awakens with eye contact to voice (<10 seconds)	
-3	Moderate sedation	Movement or eye opening to voice (but no eye contact)	
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation	TOUCH
-5	Unarousable	No response to voice or physical stimulation	

To assess sedation level

- First observe for restless, agitated behaviours
- Then speak (loudly) to patient, ask to open eyes
- If no response, use physical stimulation - start with light touch, if no response then trapezius squeeze
- Document findings

- Always be aware of patient's sedation status as can change rapidly
- Common sedative agents include propofol (as infusion), fentanyl, benzodiazepines e.g. midazolam

KEY SAFETY CONCERNS/WHEN TO CALL FOR HELP

1. Sedation can cause hypotension, particularly if bolused. **Call for help if SBP drops <90 or MAP<65 following a bolus**
2. If using bolus sedation, need to assess sedation level more frequently to ensure target is maintained
3. Sedation can wear off quickly, patients can become difficult to ventilate or agitated and remove ETT/lines – **Call for help**
4. **NEVER** use a paralysing agent without sedation
5. If using continuous sedative infusion, **NEVER** let it run out - check infusions regularly & prepare new well in advance

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